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Jeannette U. Swan v. Dr. Robert H. Lamb And Dr. Dennis D. Thoen : Brief of Appellant

Utah Supreme Court

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IN THE SUPREME COURT

OF THE STATE OF UTAH

JEANNETTE U. SWAN, :

Plaintiff and Appellant, :

vs. : Case No. 14823

DR. ROBERT H. LAMB and DR. DENNIS D. THOEN, :

Defendants and Respondents. :

BRIEF OF APPELLANT

Appeal from a Judgment of the Third District Court of Salt Lake County, Honorable Bryant H. Croft, Judge

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Defendants and Respondents.	:	

NATURE OF THE CASE

This is a medical malpractice case brought by by the plaintiff JEANNETTE U. SWAN against defendants DR. ROBERT H. LAMB, a specialist in the field of orthopedic surgery, and DR. DENNIS D. THOEN, a specialist in the field of neurology, for injuries in the form of permanent partial paraplegia, which she allegedly suffered as a result of certain diagnostic and surgical procedures improperly performed upon her spine and spinal canal by the said defendants.

DISPOSITION IN THE LOWER COURT

The case was brought, inter alia, on theories of negligence and lack of informed consent, and was tried before a jury. At trial the court refused to

allow plaintiff's expert witness to testify concerning the standard of medical care which governed defendant's conduct. Having so ruled, the court, at the close of plaintiff's evidence, granted defendants' motion to dismiss as to the negligence theory for failure to establish a prima facie case. The case went to the jury with instructions on the theory of lack of informed consent only, and the jury returned a verdict in favor of both defendants, no cause of action.

RELIEF SOUGHT ON APPEAL

Plaintiff seeks a reversal of the decision in the lower court and the grant of a new trial on grounds that the trial judge erred in stating and applying the law in Utah with respect to (1) the standard of care required of doctors who are alleged to have committed medical malpractice, and (2) the qualifications required of an expert witness in order that he be permitted to testify as to the said standard of care.

STATEMENT OF FACTS

On September 12, 1972, the plaintiff, Mrs. Jeannette U. Swan, age 68, was admitted by her private physician to the St. Mark's Hospital in Salt Lake City for diagnosis and evaluation of persistent

pains that she had been experiencing in her lower back and right leg. Transcript, day 1 at 33-34. At the time of her admission, Mrs. Swan was ambulatory and, though she found it painful at times to do so, was able to walk and move about the hospital with some facility. Tr. day 4 at 72.

The first days of her hospitalization consisted of a variety of tests and examinations. On September 13th, her motor and nerve responses were found to be essentially normal (Tr. day 2 at 5) but other tests led her doctors to believe that she might have a high degree of block in her spinal canal. Tr. day 2 at 13; 3 at 21. On the fifth day of her hospital stay, September 16, 1972, a myelogram was performed upon Mrs. Swan by the defendant Dr. Dennis D. Thoen, a neurologist. Tr. day 3 at 18. In this procedure, a quantity of spinal fluid was removed from the terminal portion of the spinal canal and replaced by injection of 10 cc of a radiographic contrast medium called pantopaque. Tr. day 3 at 20, 26-27. Mrs. Swan was then titled into various positions so that the flow of pantopaque could be observed under flouroscopy and indicate the presence or absence of defects, obstructions or other abnormalities in the area of the spinal canal. Tr. day 2 at 15; 3 at 18, 48, 69.

In the course of performing the myelogram, Dr. Thoen did not record the opening or closing spinal fluid pressures. Tr. day 3 at 24, 30. Neither did he record the quantity of spinal fluid removed prior to the injection of the pantopaque radiographic dye. Tr. day 3 at 27. At the conclusion of the myelogram, Dr. Theon did not remove the pantopaque. Tr. day 3 at 32. During the actual myelographic procedure, Mrs. Swan complained of very severe pain. Tr. day 4 at 71. Following the myelogram, the intense pain persisted and was accompanied by general weakness in her legs. Tr. day 3 at 41. Although Dr. Thoen stated that he conducted a neurological examination upon Mrs. Swan in an attempt to determine the cause of her pain and weakness, she was neither x-rayed nor flouroscoped in the ensuing days. Tr. day 3 at 42, 48-49.

Results of the myelogram showed defects consisting of narrowing or blocks at the L-1, L-2 and L-3 lumbar vertebral levels. Tr. day 2 at 15. Dr. Thoen recommended surgery to correct the defects. Tr. day 3 at 46.

On September 18, 1972, defendant Dr. Robert H. Lamb performed a lumbar decompression laminectomy upon Mrs. Swan's spine. Tr. day 2 at 21, 22, 29. The said procedure, performed in the face of changing

neurological signs (Tr. day 2 at 112) and without the benefit of a current neurological examination (Tr. day 3 at 46-47), involved the surgical removal of portions of bone in the lumbar area in an effort to cure the narrowing at the spinal canal. Tr. day 2 at 97. None of the bone removed was ever sent to the pathology lab. Tr. day 2 at 41. In what was the seventh of eight separate operations performed by Dr. Lamb that same day (Tr. day 2 at 45), he operated from the L-2 level down to L-4, but did not operate at the site of the defect indicated at L-1; neither did he use a cather to determine whether the spinal canal was clear at L-1. Tr. day 2 at 32, 112-113; Tr. day 2 at 15, 16. Mrs. Swan testified that prior to the operation Dr. Lamb assured her that she would be out of the hospital in about ten days. Tr. 4 at 73. She also testified that he told her she would be better if she had an operation. Tr. day 4 at 74.

When Mrs. Swan awoke the morning following surgery, she could not move her legs. Tr. day 4 at 75. An examination by Dr. Thoen on September 20, 1972, revealed that she was not able to move anything below her knees. Tr. day 3 at 47. On October 9, 1972, Dr. Al Martin performed a decompression laminectomy at the L-1 level of Mrs. Swan's spine. Tr. day 2

at 25, 106. This second operation failed to restore any significant capacity in the use of her lower extremities and on November 7, 1972, Mrs. Swan was discharged to the Bonneville Nursing Home as a paraplegic. Tr. day 1 at 35, 39, 44.

At the time of the trial of this case, Mrs. Swan was medically found to be suffering from paraplegia. In connection with that condition, she has lost control of her bowel and bladder function, experienced atrophy of her left lower extremity and paralysis of all nerve roots below the L-3, L-4 level, and has lost feeling in her right foot, left leg and about the saddle peritoneal areas. Tr. day 4 at 27, 28. She must wear a leg brace and use a wheelchair or walker to get from place to place in her apartment. Tr. day 1 at 43. She is required to take large doses of narcotic medications for pain. Tr. day 1 at 44.

At the trial of her case, the plaintiff, Mrs. Swan, offered the expert testimony of a neurosurgeon from Los Angeles, Dr. Peter M. Rocovich, on the issue of the standard of care required of physicians and surgeons performing myelograms and lumbar decompression laminectomies on persons like plaintiff at the time when the said procedures were performed upon her. Included among Dr. Rocovich's credentials that were presented to the court as foundation for such testimony

were the following:

The doctor received his M.D. degree from St. Louis University School of Medicine in 1942, after which he interned at Huntington Memorial Hospital in Pasadena, California. For three years, from 1943-1946, he was a general surgeon in the U.S. Army in the European theatre. Following his military service he fulfilled his residency requirements in neurosurgery at White Memorial Hospital which was associated with the Loma Linda Medical College. In 1948-1949 he served as instructor of resident neurological surgery at Albany Medical College in New York. In that assignment, he was charged with instructing and training in the fields of neurology and neurosurgery. In 1949, the doctor returned to California and started private practice where he has continued to the present. For 25 years Dr. Rocovich has headed a neurological and neurosurgical clinic at the Orthopedic Hospital of Los Angeles. The Orthopedic Hospital affiliates with the University of Southern California Medical School and is involved in teaching and training resident physicians from all over the United States. Dr. Rocovich was also the head of the Department of Neurosurgery at the Queen of Angels Hospital in Los Angeles for 12 years and served for a time on the faculty school of nursing. During such time,

said hospital had a complete training program for interns and residents as well as a medical school affiliation. Dr. Rocovich is a member of numerous medical societies, both national and regional, including the American Medical College, Western States Federation of Neurological Sciences, California Medical Association, Southern California Neurosurgical Society, and Los Angeles County Medical Association. Tr. day 3 at 100-105.

In addition to the above mentioned credentials, Dr. Rocovich testified that, over the course of his professional career he personally had performed over a thousand lumbar decompression laminectomies and over a thousand myelograms of the types that were performed upon Mrs. Swan. Tr. day 3 at 109. Dr. Rocovich was asked whether he was acquainted with standards of skill and care for neurosurgeons practicing in any states outside of California. His affirmative response was followed by the following explanation:

> From my education background, from the individual education background, from being a graduate of a grade A medical school, from being trained in various parts of the country at different times, from being accepted into the Army and with other men, other doctors from all over the states of the union and all on the same equal level in the Army, from my practice in--well, in the large communities where you have medical schools

> and where you have hospitals, where you have training programs, and you have communications and you have books, you have publications, you have the competition of one area against the other. This establishes the practice throughout the whole country and it's on the same level. Tr. day 3 at 107.

When Dr. Rocovich was asked if he had an opinion as to whether or not there was a different standard of care for various types of doctors who operate to enter the spinal canal objections by defendants were sustained for lack of proper foundation. Tr. day 3 at 109,110. Plaintiff offered to prove that the standard of care for all doctors entering the spinal canal area was the same. Tr. day 3 at 119. Plaintiff further offered to prove that myelogram and decompression laminectomy procedures of the types to which she had been subjected were routinely performed by persons in defendants' fields and, as such, were standardized in much the same way as the treatment of a broken arm. Tr. day 3 at 120.

After considering the issue of what standard of medical care to apply, the court rejected plaintiff's arguments for application of a similar community standard, (Tr. day 3 at 111), as well as a standard of the medical profession, (Tr. day 3 at 114), and ruled that Utah law required a doctor to exercise only that degree of skill and care required of the

average competent medical practitioner in defendants' same locality, Tr. day 3 at 111; furthermore, that in order to be qualified to testify on said standard of care in such a locality, a witness had to demonstrate "personal contact or experience within the State of Utah." Tr. day 3 at 118. See also Tr. day 4 at 6, 7. The trial judge ruled that since Dr. Rocovich had not practiced in Utah he could not testify as to the standard of care required of a doctor practicing in Utah.

Had Dr. Rocovich been permitted to, he would have testified that the conduct of both defendants violated the standards of care for the performance of myelograms and lumbar decompression laminectomies in Salt Lake City and areas similar to Salt Lake City during the period of September, 1972, as follows:

Dr. Thoen failed to perform and record a complete neurological examination prior to the first surgery. He left the pantopaque in the spinal canal. He failed to repeat the myelogram before surgery despite the presence of partial paralysis. He failed to record neurological findings and changes which he claims to have observed. He failed to properly record findings with respect to the myelogram procedure. Tr. day 4 at 106-107.

Dr. Lamb operated without a complete and current

neurological examination in the face of changing neurological signs following the myelogram and prior to surgery. He failed to submit surgical specimens to the pathology lab for evaluation. He failed to decompress the lamina at L-1 during the surgery he performed. He failed to use a catheter to determine whether the spinal canal was clear at the L-1 level at the time of surgery. He traumatized the nerve roots at L-3, L-4 during surgery. Tr. day 4 at 106.

Despite the court's preclusion of his opinion concerning the standard of care, plaintiff's expert was deemed qualified to express an opinion with probable medical certainty as to what caused plaintiff's injuries. He stated that Mrs. Swan's paraplegia was due to trauma which occurred principally at the time of surgery. Tr. day 4 at 44. As described by Dr. Rocovich, the irritation to the nerve roots caused by non-removal of the pantopaque caused them to be inflamed or injured. Said injury was compounded when the nerve roots were traumatized upon surgical removal of the posterior arch, thus producing immediate paralysis. Tr. day 4 at 46-47.

Plaintiff's evidence of causation, stripped of the benefit of her expert's testimony as to the standard of care, was deemed insufficient to survive defendant's motion to dismiss as to the negligence

count of her complaint. Tr. day 5 at 6. Thus, Mrs. Swan was prevented from reaching a jury with that portion of her claim.

ARGUMENT

Point I

THE TRIAL JUDGE ERRED IN REFUSING TO ALLOW PLAINTIFF'S EXPERT, A CALIFORNIA NEUROSURGEON, TO TESTIFY ON THE STANDARD OF CARE REQUIRED OF THE DEFENDANT DOCTORS.

In order to maintain an action for medical malpractice, a plaintiff-patient must prove that the defendant-physician's conduct failed to meet the particular standard of care and skill that the jurisdiction in question requires of all physicians and surgeons engaged in the same type of practice as the defendant, and that said failure was the cause of the injury claimed to have been suffered. W. Prosser, Handbook of the Law of Torts 161-166 (4th ed. 1971). In order to establish the standard, since knowledge of such things is not possessed by laymen, the plaintiff must, generally speaking, produce testimony from a medical expert who can explain said standard as defined in that jurisdiction, and can also state whether any breach thereof caused the harm complained of. See Huggins v. Hicken, 6 Utah 2d 233, 310 P.2d 523 (1957); Anderson v. Nixon, 104 Utah 262, 130 P.2d 216 (1943).

History shows that the courts of the United States have used four basic approaches in establishing the standard of care to be required of physicians and surgeons. They have variously required that such practitioners exercise the skill and care of physicians in good standing in (1) the defendant's same locality (strict locality rule); (2) the defendant's same general neighborhood (same general neighborhood rule); (3) localities similar to defendant's (similar locality rule); or (4) the medical profession (national standard rule). Annot., 37 A.L.R.3d 420 (1971); D. Louisell & H. Williams, 1 Medical Malpractice, ¶8.06 (1973).

In ruling that Dr. Rocovich did not qualify to testify as to the standard of care required of the defendant physicians in this case, the trial judge stated that decisions of the Utah Supreme Court mandated his application of the standard as practiced by doctors "in this locality," thus applying a form of the strict locality rule. Tr. day 3 at 111. The suggestion that Utah Law held doctors to the standard of care of physicians in good standing in the same or similar locality was specifically rejected. Tr. day 3 at 111. Plaintiff's arguments that changed practices and circumstances dictated the adoption of a national standard of care, especially in cases

involving defendants holding themselves out as specialists, were also rejected. Tr. day 3 at 114; 4 at 10.

It is true that, at first reading, some of the cases in which this court has referred to the medical standard of care could lead the reader to conclude that a strict locality test is required. However, a closer analysis of the decisions containing references to the subject shows that, in fact, the language of a variety of different tests appears:

Two cases describe the standard of care to be the exercise of that degree of skill and care required of an ordinarily skilled doctor, "in the community which he serves." Anderson v. Nixon, 104 Utah 262, 266, 139 P.2d 216, 218 (1943); Fredrickson v. Maw, 119 Utah 385, 387, 227 P.2d 772, 773 (1951). This language clearly reflects the strict locality rule.

At least six cases say that a doctor must exercise that degree of skill and care practiced by skilled professionals doing "the same type of work in the vicinity" or "in the same area." Baxter v. Snow, 78 Utah 217, 232, 2 P.2d 257, 263 (1931); Edwards v. Clark, 96 Utah 121, 138, 83 P.2d 1021, 1029-30 (1938), rehrg den., 96 Utah 140, 84 P.2d 768 (1938); Forrest v. Eason, 123 Utah 610, 612, 261 P.2d 178, 179 (1953); Marsh v. Pemberton, 10 Utah 2d 40, 44, 347 P.2d 1108, 1110 (1959); Paull v. Zions First National Bank,

18 Utah 2d 183, 185, 417 P.2d 759, 761 (1966); Posnien v. Rogers, 533 P.2d 120, 121 (Utah 1975). This language, only slightly broader than the strict locality rule, seems to state the same general neighborhood rule.

Two cases contain language which describes the standard to be that required of "men of similar calling under similar circumstances," Dickinson v. Mason, 18 Utah 2d 383, 386, 423 P.2d 663, 665 (1967); or "in the same or a similar locality." Baker v. Wycoff, 95 Utah 199, 212, 79 P.2d 77, 84 (1938). This language further broadens the test to include the standards of similar localities.

The only case to address the question of whether a national standard should be applied in Utah was Coon v. Shields, 88 Utah 75, 39 P.2d 348 (1934). At the time, the Court did not feel the medical profession was ready for the broader standard, but predicted the day of its eventual adoption. Coon, at 82, 39 P.2d at 350. See also Point V, infra at 47. Recently in Ficklin v. MacFarlane, 550 P.2d 1295 (Utah 1976), the Court spoke of the standard of care as being that which is "extant in medical circles." Ficklin, at 1297. Such language may reflect current judicial approaches to make the standard fit changed medical circumstances, in accordance with earlier predictions.

In order to account for the apparent lack of uniformity in language used by this Court in stating the medical standard of care, one need only consult the factual settings of the aforementioned cases. In no instance is the statement of the rule a critical element of the decision rendered in the case. Since no decision ever turned on which test was to be applied, it is natural that some imprecision could result.

Baxter v. Snow, 78 Utah 217, 2 P.2d 257 (1931); and Marsh v. Pemberton, 10 Utah 2d 40, 347 P.2d 1108 (1959) involved situations where the plaintiffs failed to offer expert testimony on the medical standard of care. Since expert testimony is generally required to establish medical standards of care, and since no experts testified on any of the possible applicable standards, it was immaterial which standard the court applied. Plaintiffs would have lost in any event. Thus, the Court's statements that defendants were held to a "same vicinity" rule were dicta and not holdings.

Additional explanation of the lack of consistency in the language on the medical standard of care to be applied appears in the cases where plaintiff's own witness, called to establish the standard of care, testified that defendants complied with it. Such

was the case in Edwards v. Clark, 96 Utah 121, 83 P.2d 1021 (1938); and Posnien v. Rogers, 553 P.2d 120 (Utah 1975). Since plaintiffs' own witnesses established the standard of care, the correctness of that standard obviously was not at issue in their respective appeals. The court's inclusion of "same vicinity" language in Edwards, and "same area" language in Posnien was not a part of the holding of either case.

In two of the cases, the competency of the plaintiffs' experts to testify on the applicable standard of care apparently was not challenged at trial, and thus did not come into question on appeal. In both Baker v. Wycoff, 95 Utah 199, 79 P.2d, 77 (1938), where the court spoke of a "similar locality" test, and Forrest v. Eason, 123 Utah 610, 261 P.2d 178 (1953), where the court described a "same vicinity" test, the expert witness testimony offered by plaintiffs on the standard of care was allowed at the trial level. In Baker, where the plaintiff prevailed, the defendant did not challenge the correctness of the standard as applied and is was not treated as an issue in the case on appeal. In Forrest, where the defendant prevailed, the correctness of the standard of care as established by plaintiff's own witness was obviously not addressed

on appeal. The tests announced in both cases were, therefore, unnecessary to the holdings of the cases, and, as stated, served only an illustrative role in the written decisions.

In still another group of cases, the facts were such that either the standard of care and the breach thereof were stated to be adequately established by the evidence, or, for the purposes of the appeal, were assumed to have been established. Whether the correct standard was applied or not was irrelevant to the outcome of the case since it obviously was decided on other grounds. In Paull v. Zions First National Bank, 18 Utah 2d 183, 417 P.2d 759 (1966); Anderson v. Nixon, 104 Utah 262, 139 P.2d 663 (1967); and Dickinson v. Mason, 18 Utah 2d 388, 423 P.2d 663 (1967), the court assumed a breach of the standard of care, but said that said breach was not proven to be the proximate cause of plaintiff's disability. Whichever standard was applied was therefore not outcome determinative and cannot be relied upon as the rule of the case.

Similar logic applies in the analysis of Fredrickon v. Maw, 119 Utah 385, 227 P.2d 772 (1951) wherein the court held that defendant's conduct was violative of the strict locality rule as a matter of common knowledge. (Defendant sutured a surgical sponge in the wound created by a tonsillectomy.)

Obviously if defendant's conduct violated this narrowest of standards, it would also have violated any one of the broader standards. The standard announced by the court here, as in the cases cited above, was not part of the holding of the case.

It is interesting to note that in Coon v. Shields, 88 Utah 76, 39 P.2d 348 (1934), probably the only case in which the court was directly presented with the opportunity to decide whether to apply the strict locality rule, or the similar locality rule, it chose to adopt neither, stating as its reason the following:

> [W]hether we adopt the rule of limitation to a particular community or a rule of limitation to similar communities, it would not affect this case . . . . Coon, at 83, 39 P.2d at 351.

When the trial court in the instant case applied a form of the strict locality rule on the presumption that such a position was mandated by the decisions of the Supreme Court, it committed an error which prejudiced the rights of the plaintiff Jeannette U. Swan. As has been shown, although this Court has included in its opinions several statements relating to the standard of care applicable in medical malpractice cases, it has never, by way of holding, adopted any one of the four basic standards to which it has at various times referred. In this sense, the issues arising in the instant appeal

present a case of first impression to the Court. Those issues are: (1) What standard of care should be applied to the medical profession in Utah?, and (2) Whether an otherwise qualified expert who lacks only personal experience and contact with Utah Physicians should be precluded from testifying on the said standard of care.

POINT II

THE STRICT LOCALITY RULE IS AN ANACHRONISM WHICH HAS OUTLIVED ITS PURPOSE AND USEFULNESS IN EVEN THE VERY FEW JURISDICTIONS IN WHICH ITS OPPRESSIVE EFFECTS ARE STILL FELT.

As described above, the strict locality rule states basically that a medical practitioner has the obligation to his patient to possess and employ only such reasonable skill and care as is commonly had and exercised by other medical practioners in the particular locality or community in which he practices. Annot. 37 A.L.R.3d 420, 426 (1971); 40 Fordham L. Rev. 435, 438 (1971). This particular rule was developed late in the 1800s for the purpose of protecting the rural and small town practitioner who was presumed (perhaps with good reason), to be less adequately trained and informed than his big city brother. Waltz, The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation, 18 DePaul L. Rev. 408, 410 (1969). One court, quoting

from an early author, supplied the following explanation for the adoption of such a standard:

> There are many neighborhoods, in the west especially, where medical aid is of difficult attainment. Yet cases of disease and surgery are constantly occurring, and they must of necessity fall into the hands of those who have given the subject but little if any thought. * * * In such cases no more can be expected of the operator than the exercise of his best skill and judgment. Tefft v. Wilcox, 6 Kan. 46, 63 (1870).

Under the conditions of geographic isolation that prevailed in the frontier days, when distances were great and the mode of travel was in keeping with muddy lanes, swollen streams and impassable mountains, it was natural for the standards of practice between locality to be markedly different. Opportunities for observation, experience and consultation were strictly limited; and the fact that news of medical developments appeared only in the pages of the few scattered medical journals or in an occasional handwritten letter made it logical that the village doctor, making his rounds to the homes of his patients and fighting to provide them with what care and attention he could, would be judged by a different standard. Comment, 16 St. Louis U.L.J. 497, 505 (1972); Ellin, The Law of Medical Malpractice in Maryland: A Plaintiff's Dilemma, 3 Balt. L. Rev. 207, 212 (1974); 14 Stan L. Rev. 884, 886 (1962).

The conditions under which such doctors labored made it impossible for them to be attuned to the developments in their profession and the practices of their colleagues. One author provides the following insights into those early days:

> The general practitioner "who rode west . . . slept on the ground when he could to avoid flea-infested cabins and inns, where a dozen men were customarily lodged in a room with three or four in each bed. He crunched through winter forests on snowshoes, forded swollen rivers on his horse in the spring, and rode sweating down the hot trails of summer. Often the only drugstore in hundreds of miles was in his saddlebag. He pounded his own drugs, made tinctures and infusions, and put up prescriptions with the aid of horn balances and a china mortar." G. Marks & W. Beatty, The Story of Medicine in America 144 (1973).

Despite possible historical and circumstantial justifications for the formulation of the strict locality rule, it is interesting to note that it was never adopted in England (Waltz, 18 DePaul L. Rev., supra at 410), and was only adopted in a small minority of American jurisdictions. 41 Am.Jur. Physicians and Surgeons §87 (1942). The reason for this becomes apparent as one begins to examine and evaluate some of its drawbacks.

One problem that is encountered upon application of the strict locality rule is its tendency to make possible the creation of an insulated pocket of incompetent medical practice in a given locality.

Because the rule, as formulated, allowed application only of the standard extant in a defendant's community, it literally demanded that a medical expert testifying for the plaintiff be personally familiar with the practice there. Waltz, 18 DePaul L. Rev., supra at 410. If plaintiff's expert did not come form defendant's home town, he arguably did not have the proper experience to testify against the defendant.

The effective result of the strict locality rule was to immunize from malpractice liability any doctor who happened to be the sole practitioner in his community. As stated by one author, under a technical application of such a rule, a doctor could get away with "treating bone fractures by the application of wet grape leaves and yet remain beyond the criticism of more enlightened practitioners from other communities." Id. at 411. Similarly a group of incompetents could set up practice in a community and, by uniformly practicing a substandard form of medicine, insulate themselves from any form of malpractice liability.

Another problem that is encountered in applying the strict locality rule stems from the natural reluctance of physicians who work together and whose paths cross, to testify against one another. It is

true that the American Medical Association, interpreting its Principles of Medical Ethics, states that a "physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession . . . ." American Medical Association, Opinions and Reports of the Judicial Council 15 (1966). However, the difficulties experienced by plaintiffs in finding doctors willing to testify in their behalf have been recognized by courts, legislatures, and commentators alike. Douglas v. Bussabarger, 73 Wash.2d 476, 438 P.2d 829 (1968); Steiginga v. Thron, 30 N.J. Super. 423, 105 A.2d 10 (App.Div. 1954); Salgo v. Leland Stanford University, 154 Cal.App.2d 560, 317 P.2d 170 (1957); Pederson v. Dumouchel, 72 Wash.2d 73, 431 P.2d 973 (1967); Johnson v. Winston, 68 Neb. 425, 94 N.W. 607 (1903); Mass. Ann. Laws ch. 233, §79C (1974); Belli, An Ancient Therapy Still Applied: The Silent Medical Treatment, 1 Vill. L. Rev. 250 (1956); Markus, Conspiracy of Silence, 14 Clev.-Mar. L. Rev. 520 (1965).

Even in cases where the physician's wrongdoing is most egregious there is a decided unwillingness of doctors to take the stand for the plaintiff-patient. Dean William Prosser cites a survey made by the Boston University Law-Medicine Research Institute, as reported in Medical Economics, August 28, 1961,

in which the reality of physician reluctance to testify is most forcefully illustrated.

> [O]ut of 214 doctors, only 31% of the specialists and 27% of the general practitioners said they would be willing to appear for the plaintiff if a surgeon, operating on a diseased kidney, removed the wrong one. W. Prosser, Handbook of the Law of Torts 227, n.3 (4th Ed. 1971).

Though such a reluctance on the part of doctors to take the stand on behalf of a victim of malpractice may seem improper, it is not difficult to understand. Many doctors naturally hesitate to injure friends and fellow-craftsmen. Some fear the foreign atmosphere of the courtroom and the rigors of undergoing cross-examination. Still others are reluctant to suffer the loss of time and income from practice that may be involved in a courtroom appearance. U.S. Department of Health, Education, and Welfare, Report of the Secretary's Commission on Medical Malpractice 36-37 (1973). One case reported that an insurance company cancelled the professional liability policy of a doctor who had the temerity to testify against a fellow practitioner being sued for malpractice. The defendant was insured by the same company. L'Orange v. Medical Protective Co. 394 F.2d 57 (6th Cir. 1968). Though this case is not necessarily indicative of the actions of all malpractice insurers, it cannot be gainsaid that many pressures are exerted on the

physician to discourage his cooperation with plaintiffs in malpractice cases. It would be unrealistic to suppose that a plaintiff would be able to produce the necessary expert witnesses to establish his case under a strict locality rule.

Defendants, on the other hand are able to obtain whatever local experts they may need at the trial of a malpractice case. Evidence of this fact is found in the recent case of Capobianco v. Gordon, 19 Md.App. 662, 313 A.2d 517 (1974). There the gratuitous services of a panel of experts from a Medical-Chirurgical Faculty were offered to a defendant physician to help in the defense of his case. A letter written to the defendant by counsel for the Med-Chi Faculty contained the following:

> Dear Dr. Gordon:
>
> I confirm the referral by Med-Chi to this office of your defense pursuant to its By Laws.
>
> I should appreciate your insurance carrier and its counsel advising me of such time, if any, as it would consider a panel of doctors to be of assistance in this matter.
>
> In the meantime, you are cautioned to restrict communication on the subject to authorized representatives of your carrier, its counsel and this office.
>
> Very truly yours,
> /s/ John F. King
> JOHN F. KING

Capobianco, at 664, 313 A.2d at 518. (Emphasis added.)

The foreclosure to plaintiff of all opportunity to meet such determined opposition by disallowing the production of an expert from a more disinterested medical area is inimical to the cause of justice.

Probably the biggest problem with the strict locality rule is that it is blind to the realities of modern medical science. While it may have served a valid purpose in frontier times, it has no place in jurisprudence today. As observed by one court:

> [T]imes have changed. Modern means of transportation permit country doctors to attend up-to-date medical seminars; the general circulation of medical journals makes new developments readily available to them, and they can easily and quickly communicate with the most modern and up-to-date medical centers in cities throughout the United States * * * [T]oday's rural practitioner can and does give and receive advice transmitted thousands of miles over the telephone, and he is expected to keep himself apprised of recent developments as they are regularly published in medical journals. Douglas v. Bussabarger 73 Wash.2d 476, 438 p.2d 829, 837 (1968).

No longer does the medical community consist of a patchwork of isolated practitioners whose particular brand of medicine requires legal protection from comparison to the standards adhered to in other areas of the United States. "Surely there could be found today few physicians who would defend the notion that their brothers in some parts of the country are, or should be permitted to be, less

competent than those in other regions, based not on impermissibly variant education and training but on some inexplicable depressing force of geography alone." Waltz, 18 DePaul L. Rev., supra at 420. The courts have recognized the realities of today's medical environment and have considered the inequities produced by the strict locality rule and, with few exceptions, have abandoned it. Thus, they have acknowledged that "the legal rule ceases when the reasons for it cease." D. Louisell and H. Williams, 1 Medical Malpractice ¶8.06 (1973). (See Point V, infra at 42, for a discussion of the nationally uniform standards of medical practice.)

In the present case the trial judge quoted from a Nevada case, Lockart v. MacLean, 77 Nev. 210, 361 P.2d 670 (1961), to support his decision to reject testimony by Dr. Rocovich on the standard of care to be applied. Tr. day 4 at 7. The circumstances of that case make is inapposite to the matters at issue here. Lockart involved a malpractice suit brought against a Reno doctor and hospital by a plaintiff who developed a bone infection subsequent to surgery. In his complaint plaintiff alleged that defendants "'did not exercise the degree of care, skill and learning ordinarily possessed by hospitals

and physicians and surgeons practicing in the same locality.'" Lockart, at 671. (Emphasis added.) As his expert witness, plaintiff offered an osteopath from California who based his testimony on "his knowledge of the standard of conduct of surgeons and orthopedic surgeons practicing throughout the United States." Lockart, at 673. The expert was held to be incompetent to testify.

As can be seen, the trial court in Lockart was forced by the pleadings to apply the strict locality rule. Plaintiff in effect elected the standard by which his expert's competence was to be judged. Under that standard his expert failed to qualify. The present case contains no such procedural justification for the preservation of the jurisprudential relic known as the strict locality rule.

POINT III

THE SAME GENERAL NEIGHBORHOOD RULE IS A RESTATEMENT OF THE STRICT LOCALITY RULE CONTAINING THE SAME DEFECTS AND CREATING THE SAME PROBLEMS AS ITS PREDECESSOR.

In recognition of the near insuperable handicap which had been imposed on the victims of malpractice who, under the strict locality rule, were required to produce local expert witnesses where none were to be found, the courts in many jurisdictions attempted to modify the rule. One such modification was the formulation of

the "same general neighborhood" rule which, by holding a doctor to practice medicine in accordance with the standards of physicians in good standing in his same general area, allowed a malpractice plaintiff to produce experts that were not from the defendant's hometown, though they were from places nearby. Thus, in Willard v. Norcross, 86 Vt. 426, 85 A. 904 (1913), plaintiff was allowed to introduce expert testimony of doctors that practiced 40 miles away from the town where the defendant practiced. Also in Geraty v. Kaufman, 115 Conn. 563, 162 A. 33 (1932), plaintiff's expert from Bridgport, Connecticut, was allowed to testify on the standard of care in defendant's hometown of New London, Connecticut.

With the transportion and communication advances of later years, some courts, applying the same general neighborhood rule, expanded the boundaries of the "neighborhood" slightly to include larger land areas. See Campbell v. Oliva, 424 F.2d 1244 (6th Cir. 1970). However, by preserving the geographical insularity of a particular area, the same general neighborhood rule perpetuates many of the same problems as existed under the strict locality rule. In effect, it is merely a new name for the strict locality rule, the only difference being a moderate enlargement of the locality.

Implicit in a court's adoption of any rule which

requires conformance to standards of care of only a given geographical neighborhood is the idea that the standards of care in that area should be permitted to be different from other areas. Also implicit in the establishment of a geographical neighborhood is the idea that the standards within that neighborhood are or should be uniform. Thus, if the State of Utah were to be set apart as being a "general neighborhood" it would be on the implicit assumption that the standards of care for physicians in the state were uniform, but that those standards, as compared with physicians of other states, were different, i.e. higher or lower.

If the standards of care in other states were lower than in Utah, a rule precluding the testimony of out-of-state experts on the standards familiar to them would be unnecessary. Utah doctors would be practicing at a higher level. If the standards of care in other states were higher than Utah's the courts, by excluding expert testimony from out-of-state witnesses, would foster and perpetuate medical inferiority on a statewide basis. This court cannot, without believing that Utah standards are justifiably lower than those of other states, countenance the application of a same general neighborhood rule in such a way as to affirm the lower court's decision to reject testimony from Dr. Rocovich.

The same general neighborhood rule likewise fails

to cure the problems created by physician reluctance to testify for a plaintiff in a malpractice case. The mobility enjoyed by today's doctor has resulted in his knowing or being known by a large number of his fellow practitioners from all over the state. Close collegial relationships develop as doctors attend the same seminars, conferences and symposia, belong to the same organizations, refer patients to each other and rely on each other for consultation and advice. The climate that develops operates to discourage a doctor from testifying against someone he has met or might meet. The vitality of a rule must be questioned when it can prevent a patient with a legitimate claim from reaching a jury with his cause because, when he could not find a "neighborhood" physician to testify in his behalf, he obtained help from out-of-state.

As with the strict locality rule, the same general neighborhood rules ignore the realities of contemporary medical practice. Standards of medical care in Utah are as high as those in California and the rest of the nation. Were it otherwise, patients would elect to receive all but emergency treatment outside of the state. The treatment of Mrs. Swan was not an emergency. Tr. day 2 at 16. Also Dr. Rocovich was prepared to testify that myelograms and decompression laminectomies were not esoteric procedures, but were performed routinely by neurologists,

orthopedists and neurosurgeons. Tr. day 3 at 119. The standard of care for their performance was well established throughout the country, and was the same. Id.

Utah doctors already enjoy a degree of legal protection not afforded other citizen tortfeasors. With the passage of the Utah Health Care Malpractice Act, they have the protection of a shorter statute of limitations, insulation against liability for breach of implied contract and warranty, entitlement to the service of an advance notice of intent of any plaintiff to commence an action against them for malpractice, plus special buffers against liability for failure to obtain a patient's informed consent to treatment. See Utah Code Annotated, §§78-14-4, 78-14-6, 78-14-8, 78-14-5, (Supp. 1976). When the Washington Supreme Court observed the preferred status granted to the medical profession in that state, it refused to affirm the trial court's application of even the broader "similar community" rule opting instead for the "general professional" or national standard, Douglas v. Bussabarger 73 Wash.2d 476, 438 P.2d, 829, 838 (1968). It said,

> If we were to affirm the judgment of the trial court, not only would we perpetuate the advantageous position of the medical profession, but we would exaggerate and extend it unnecessarily. Douglas, at 831.

Affirmance of the trial court decision in the present

case would necessitate adoption by this court of a form of outmoded and unjust strict locality rule. The facts of contemporary medical practice demand the adoption of a rule more reflective of reality.

POINT IV

THE SIMILAR LOCALITY RULE OFFERS AN ENLIGHTENED APPROACH TO THE STANDARD OF CARE TO BE APPLIED IN MEDICAL MALPRACTICE CASES WHICH, IF APPLIED IN THIS CASE, WOULD HAVE ALLOWED PLAINTIFF'S EXPERT TO TESTIFY ON THE STANDARD OF CARE.

The majority of jurisdictions in the United States have modified the harsh effects of the strict locality and same general neighborhood rules by adopting a test which holds a defendant practitioner to the standard of skill and care ordinarily observed by other physicians in good standing in the defendant's same or a similar locality. Annot. 37 A.L.R.3d. 420, 426 (1971); King & Coe, The Wisdom of the Strict Locality Rule, 3 Balt. L. Rev. 221, 222 (1974).

At first, some courts elected to interpret "similar locality" to mean similar in terms of socioeconomic and geographic factors, e.g. size of population, type of economy, geographic proximity, etc. See Michael v. Roberts, 91 N.D. 499, 23 A.2d 361 (1941); Morrill v. Komasinski, 256 Wis. 417, 41 N.W.2d, 620 (1950); Allen v. Voje, 114 Wis. 1, 89 N.W. 924 (1902). More recently, however, courts which continue to apply the "similar

locality rule" have tended to reject a purely socioeconomic or geographic approach and have instead looked toward the similarity or "medical factors" such as medical schools, teaching hospitals and research and laboratory facilities in the localities to be compared. See Cook v. Lichtblau, 144 So.2d 312 (Fla. Dist. Ct. App. 1962); Sampson v. Veenboer, 252 Mich. 660, 234 N.W. 170 (1931); Cavallero v. Sharp, 84 R.I. 67, 121 A.2d 669 (1956); Teig v. St. John's Hospital, 63 Wash.2d 369, 387 P.2d 527 (1963). See also 40 Fordham L. Rev. 435, 439 (1971); 14 Stan. L. Rev. 884, 890 (1962).

One commentator described as follows the conditions under which an expert could be qualified to testify in a malpractice case applying the similar locality rule:

> The modern view of a majority of courts is that a medical expert is free to testify in a malpractice case if his community or other communities with which he is familiar bear sufficient similarity to that of the defendant. And in determining similarity the courts will not now look to such socio-economic facts as population, type of economy, and income level but to factors more directly relating to the practice of medicine. In the main, an expert practicing in a locality having medical facilities comparable to those existing in the defendant's community is permitted to testify concerning the standard of care governing the defendant. The number and quality of hospitals, laboratories and medical schools are typical considerations. Of course, the nature of the community in which the witness currently practices is irrelevant if he happens also to possess familiarity with standards in the

defendant's locale or in areas sufficiently similar to it. Waltz. 18 DePaul L. Rev. supra at 415.

In Riley v. Layton, 329 F.2d 53 (10th Cir. 1964), the 10th Circuit Court of Appeals, applying Utah law, affirmed the decision of the trial court to admit the expert testimony of a San Francisco general practitioner called by plaintiff to establish the medical standard of care for treating bone fractures in Kanab, Utah. Of interest in the Riley case is the fact that the foundation laid for said expert's testimony dealt not with geography or population but with similarities in medical practice. The evidence was that plaintiff's expert had operated a 20-bed hospital in a small Texas town, had set and casted between 120 and 150 fractures similar to the ones in question and, "through his experience, reading, lectures and travels, was familiar with the practice in small towns throughout the United States. . . ." Riley, at 57. (Emphasis added.) Furthermore, it was established that the standard of care for general practitioners was approximately the same in Kanab as in Salt Lake City and San Francisco. Since the communities with which plaintiff's expert was familiar were similar as to treatment of fractures, he was deemed to have been properly qualified to testify.

In Dickens v. Everhart, 284 N.C. 95, 199 S.E.2d 440 (1973), the trial court refused to allow a California pathologist to testify as to whether the defendant North Carolina doctor's treatment of plaintiff

was in accord with accepted medical practice on the grounds that said pathologist was not actually acquainted with medical practices in the North Carolina community where defendant practiced. On appeal the trial court was held to have erred in its ruling. The court said that such testimony from the California pathologist should have been admitted since he was familiar with the standard of professional competence and care customary in communities similar to defendant's among physicians engaged in his field of practice.

Hundley v. Martinez, 151 W.Va. 977, 158 S.E.2d 159 (1967) also addressed the question of the competency of out-of-state expert witnesses to testify on the medical standard of care in a jurisdiction using the similar locality approach. In Hundley, plaintiff introduced deposition testimony from a New York opthalmologist on the standard of care in a community similar to Charleston, West Virginia. After noting that the reasons for the former strict application of the locality rule had largely disappeared, the court observed that although the witness did not testify that he was personally familiar with the standard of care for performance of cataract operations in Charleston, West Virginia, he nevertheless did testify that he was fimiliar with the standard of care observed in such operations throughout the entire country. The court said that such testimony was sufficient

to show his familiarity with the standard of care in Charleston, because if the witness was familiar with the standard procedure for performing cataract operations throughout the entire country, his familiarity with such standard procedure therefore embraced Charleston, West Virginia. The court stated that it was rejecting a strict application of the locality rule and was holding instead that since the witness was sufficiently familiar with the standard of medical practice in areas similar to Charleston, he was therefore sufficiently familiar with the standard of Charleston to be competent to testify in the case.

Should the court conclude that the proper rule to apply in Utah with respect to the medical standard of care, is the similar locality rule, logic, reason and reality dictate that the correct measure of an area's similarity is not geographic proximity or demographic composition, but the similarity of medical factors such as the presence of or access to medical schools, hospitals, laboratories, research facilities, equipment, speciality assistance, libraries, reference materials and publications.

Under such a test Dr. Rocovich was properly qualified to give testimony on the standard of care to be applied. Plaintiff offered to prove that the Los Angeles and Salt Lake City medical communities were similar. Tr. day 4 at 15. The court, however, rejected the offer. Id. at 16. Testimony that was introduced either directly or by way of proffer established that

like Los Angeles, Salt Lake City, through facilities at the University of Utah, was a regional medical center serving a large geographic segment of the western United States. Tr. day 4 at 15. The Orthopedic Hospital of Los Angeles with which plaintiff's expert is associated, is affiliated with an accredited medical school and provides a complete training program for interns, while both it and the Queen of Angeles Hospital provide a complete training program for residents. Tr. day 3 at 104; American Hospital Association, The AHA Guide to the Health Care Field 32 (1972). Hospitals in Salt Lake City have similar affiliations with and access to the expertise at the University of Utah Medical School, and offer training programs for interns and residents. Tr. day 3 at 107. AHA Guide, supra at 223. The programs in which residency training is conducted in Los Angeles as well as Salt Lake City are supervised by national accreditation agencies which require compliance with the same standards of training and practice in the separate localities. Tr. day 4 at 13; 14 Stan. L. Rev. 884, 888, n.20 (1962). Plaintiff's expert testified that the University of Utah Medical School was "a very good one." Tr. day 3 at 107. He said that because of the quality of the school, the physicians of Salt Lake City were able "to offer good medical care to the people of this community like all good medical schools should . . . and do." Tr. day 3 at 107. Both the Queen of Angeles Hospital and the Orthopedic

Hospital of Los Angeles are and have been accredited from some time. Tr. 3 at 108. Accreditation is granted by a national organization which requires compliance with certain standards set for the medical staff; and the nursing, anesthesia, dietetic, emergency, environmental, medical records, nuclear medicine, pathology, pharmaceutical and library services, to name a few. See Joint Commission on Accreditation of Hospitals, Accreditation Manual for Hospitals (1970).

Each year the American Hospital Association publishes a list of U.S. Hospitals in which it itemizes the nature of facilities contained therein and approvals granted thereto. In 1972, the list showed important medical similarities between the Queen of Angels and the Orthopedic Hospital of Los Angeles, where Dr. Rocovich practices, and the St. Mark's Hospital of Salt Lake where Dr. Thoen and Dr. Lamb practice. Common to the said Los Angeles Hospitals and the St. Mark's Hospital were the following facilities: postoperative recovery room, intensive care unit, pharmacy with FT registered pharmacist, histophathology laboratory, blood bank, electroencephalagraphy capabilities, inhalation therapy departments, physical therapy departments, emergency departments, social work departments, intensive cardiac units, psychiatric emergency services, organized outpatient departments, hospital auxiliaries and volunteer services departments. American Hospital Association, The AHA Guide to the Health

Care Field 32, 223 (1972). When other Salt Lake and Los Angeles hospitals are compared, it can be seen that as of 1972 both localities contained very complete hospital facilities according to the American Hospital Association. Id.

There is ready access to medical literature in both Salt Lake City and Los Angeles. The University of Utah Medical School has a very complete library, and each accredited hospital is to provide books, periodicals and other materials appropriate to meet the needs of the medical and hospital staff. Joint Commission of Accreditation of Hospitals, Accreditation Manual for Hospitals (1970). Dr. Rocovich testified that he had ready access to the libraries of the Los Angeles County Medical Association, Queen of Angels Hospital, Orthopedic Hospital of Los Angeles, and the medical schools at the University of Southern California and the University of California at Los Angeles. Tr. day 3 at 108-109.

In addition to stating his professional and educational credentials, Dr. Rocovich testified that he had personally performed in excess of 1,000 myelograms and 1,000 lumbar decompression laminectomies of the type performed by defendants upon Mrs. Swan. (Tr. day 3 at 109). Had the court applied the similar locality rule to the medical standard of care, it would have allowed Dr. Rocovich to express an opinion thereon and could not have granted defendants' motion to dismiss on the grounds that it did.

POINT V

IT WOULD BE CONSISTENT WITH THE REALITIES OF MEDICAL PRACTICE TODAY TO REQUIRE COMPLIANCE BY THE MEDICAL PROFESSION, ESPECIALLY ITS SPECIALISTS, WITH A NATIONAL STANDARD OF CARE.

Physicians practicing as specialists in the treatment of some particular condition have consistently been held to a higher standard of care than their generalist collegues. Rather than be held only to the standards of practice in localities similar to his, the specialist is required to exercise that degree of skill and care ordinarily possessed and used by similar specialists. Annot. 21 A.L.R.3d 953 (1968). Restatement (Second) of Torts §299A, Comment d (1965). In an article prepared for the American Medical Association Office of General Counsel the following comment concerning the standard of care required of specialists appeared:

> The specialist is increasingly presumed to have kept up with his field, and courts point out in numerous decisions that the reason a patient consults a specialist is in order to see a physician who has kept up with advances in medicine. Therefore, an increasing number of courts find it appropriate to hold specialists to a national standard of due care. Holder, Standard of Care for Specialists, 226 J.A.M.A. 395, 396 (1973).

In Kronke v. Danielson, 108 Ariz. 400, 499 P.2d 156 (1972) the plaintiff, in a malpractice action against an Arizona specialist, called a Los Angeles neurosurgeon as her expert witness. At trial the court ruled plaintiff's expert incompetent to state what the standard of care was

in the community where the defendant practiced, on the grounds that he had no personal experience in the state. The Arizona Supreme Court reversed.

> We hold that, for a plaintiff to recover in a malpractice case involving a specialist, he must prove that the defendant specialist in his acts failed to meet the standard of care required of physicians in the same speciality practiced by the defendant. Kronke at 159.

The court further held that for an expert to qualify to express an opinion on what that standard of care is he must be shown to have knowledge of and familiarity "with the standard of care and treatment commonly practiced by physicians engaged in the same type of speciality as the defendant." Id.

A similar result was reached in Nacarrato v. Grob, 384 Mich. 248, 180 N.W.2d 788 (1970). There the trial court was reversed for not allowing two specialists, one from Los Angeles and another from Chicago, to testify for the plaintiff in a malpractice case against a Detroit specialist. The Michigan Supreme Court said,

> The reliance of the public upon the skills of a specialist and the wealth and sources of his knowledge are not limited to the geographic area in which he practices. Rather his knowledge is a specialty. He specializes so that he may keep abreast. Any other standard for a specialist would negate the fundamental expectations and purpose of a specialty. The standard of care for a specialist should be that of a resaonable specialist practicing medicine in light of present day scientific knowledge. Therefore, geographical conditions or circumstances control neither the standard of a specialist's care nor the competence of an expert's testimony. Nacarrato, at 791.

The incorporation into the law of a national standard of care for specialists is simply a recognition of that which the doctors themselves did long ago. The establishment and maintenance of national standards for specialists has long been a purpose and function of the American Board of Medical Specialities. Marquis--Who's Who, 1 Directory of Medical Specialists xvii (15th ed. 1972). The Board, by means of comprehensive written and oral examinations administered on a nationwide basis to qualifying candidates, determines and certifies the competence of its members. Id. at xviii; Tr. day 2 at 2; 3 at 65-66. Such a program results in the establishment of a uniform standard of care throughout the United States in each specialty field.

Both defendant physicians testified that the standard of care in their particular specialties was uniform throughout the country. During examination of defendant Dr. Lamb, the following exchange occurred:

> Q. Doctor, I understand you are . . . a certified board member of orthopedics?
> A. American Board of Orthopedic Surgery, yes.
> Q. And that board is governed by a national standard, is it not?
> A. Yes.
> Q. And orthopedists from Salt Lake City would take the same test that orthopedists from California would take, would be held at the same standards; is that correct?
> A. Yes, it is a national test.
> Q. And the principles of orthopedic surgery have become pretty well nationalized, haven't they?
> A. Yes.

Tr. day 2 at 2.

Defendant Dr. Thoen said much the same thing:

> Q. Doctor, is the standard of skill and care for neurologists . . . uniform within the United States?
>
> A. The standard of care for board certified neurologists is supposed to be uniform throughout the states, yes.

Tr. day 3 at 5. See also Tr. day 3 at 67.

Dr. Thoen went on to agree that the standard of care required of non-board certified neurologists was the same as for certified neurologists. Tr. day 3 at 6.

When one examines the educational backgrounds of the Utah specialists certified in the specialty fields of orthopedic surgery and neurology as of 1972, it can be readily appreciated that geography is not determinative of standards of care. Utah orthopedic specialists, for example, studied in Utah, California, Washington, D.C., Hawaii, Minnesota, Illinois, Louisiana, Pennsylvania, Texas, New York, Kentucky, Maryland, Michigan, Tennesse, New Mexico, Washington, Wisconsin, Massachusetts, Oregon, Kansas, Indiana, New Jersey and Ohio. Marquis--Who's Who, 1 Directory of Medical Specialists 1059 (15th ed. 1972). Utah neurology specialists studied in Utah, Colorado, Illinois, Texas, Michigan, Pennsylvania, Minnesota, New York, Alaska, California, Maryland and Massachusetts. Id. v. 2, at 1820-21. The defendants in this case have studied in Pennsylvania, Ohio, Iowa and Massachusetts in addition to Utah. Tr. day 2 at 1, 76; 3 at 1, 2, 75.

The defendants in this case are both certified specialists who, by their own admissions, are governed by a national

standard of care. As was stated by one court, "A defendant should not be judged by a lower standard than he himself requests." Douglas v. Bussabarger, 73 Wash.2d 476, 438 P.2d 829, 837 (1968). It was error for the trial court to have applied the rule that it did in the face of defendants' admissions.

In 1934, the Utah Supreme Court was presented with the question of whether a general medical professional standard of care should be applied in judging the conduct of a physician charged with malpractice. Coon v. Shields, 88 Utah 76, 39 P.2d 348 (1934). The issue arose when, following treatment of plaintiff's fractured leg, gangrene set in necessitating its amputation. Among plaintiff's allegations of negligence against her doctor was the claim that he failed to clean and disinfect her leg wound. At trial, one of the questions propounded to plaintiff's expert was ". . . what methods according to the present standard of care and skill and state of medical science might be 'done' in the way of cleaning the wound." Coon, at 82, 39 P.2d at 350. The trial court ruled out the answer to this and other questions asked of the expert and, at the close of the evidence, directed a verdict for the defendant. Plaintiff appealed.

In addressing the propriety of the trial court's ruling with respect to the above question, the court upheld the rejection of a national standard as set by the medical profession. However, in so holding, the court joined unanimously in predicting the eventual adoption of such a

standard in Utah:

> When we consider the modern advanced stage of the medical profession, the many facilities for communication and dissemination of the latest developments in the various sciences involved in the practice of that profession, we can say that there is some justice in contending that the standard of care required of a physician or surgeon should not be limited to any particular community or locality in an effort to recognize a natural migration of the more skilled to the larger centers of population. The time will undoubtedly come when such limitation will fall by the wayside. Is that time here now? We believe not, and cite as our reason for so believing the fact that in these Western States there are still many communities cut off from the advantages of easy communication with the outside world. Coon, at 82-83, 39 P.2d at 350.

Developments since 1934 clearly demonstrate that as predicted by the Court, the time has come for the geographical limitations of medical standards to "fall by the wayside." Advances in the fields of transportation and communication alone virtually assure today's physician ready access to current information, modern hospital facilities, and skilled specialists in all but the most serious emergency situations.

Seventeen years ago Louisell and Williams wrote of the many aids then readily available to physicians to help them keep abreast of developments in their profession. Among the aids listed were:

> The "comprehensive coverage" of the Journal of the American Medical Association, the availability of numerous other journals, the ubiquitous "detail men" of the drug companies, closed circuit television presentations of medical subjects, special radio networks for physicians, tape recorded digests of medical literature, and hundreds of widely available post graduate courses. D. Louisell & H. Williams, The Parenchyma of Law 183 (1960).

The authors observed that the medical profession was, through such means, establishing national standards. They then added, "Medicine realizes this, so it is inevitable that the law will do likewise." Id. at 184.

In addition to the items mentioned above, many other factors contribute to the establishment of nationally uniform standards for doctors. As a condition of licensure in most states, a doctor must have graduated from an accredited medical school which, in order to qualify for such accreditation, must meet rigid standards imposed by national organizations of the American Medical Association. See Medical Education in the United States, 210 J.A.M.A. 1455, 1460 (1969). Internship and residency programs in hospitals likewise require special approval by national organizations, which approval is contingent upon the hospital being accredited by the Joint Committee on Accreditation of Hospitals, an arm of the American Hospital Association. See 14 Stan. L. Rev. 884, 888, n.20 (1962). The role of the specialty boards in setting uniform standards of care has already been mentioned. See supra, at 44.

The federal government is also beginning to play a significant role in the establishment of uniform national standards of care. Nearly half of the money for America's medical schools now comes from the federal government. Lee, Medical Education--A Brief History, Medical and Health Annual 29 (Encyc, Brit. 1977). With the recently enacted federal

statute creating Professional Standards Review Organizations, the Secretary of Health, Education and Welfare is empowered, under certain circumstances, to establish uniform standards of care. 42 U.S.C.A. §1320c-1 et. seq. (1974). The standards required of health care providers qualified to administer treatment under the Medicare and Medicaid programs are also detailed, exacting and nationally consistent. 42 U.S.C.A. §1395 et. seq. (1974), and applicable regulations.

As stated by the Supreme Judicial Court of Massachusetts when it struck down the locality rule in its jurisdiction, "The time has come when the medical profession should no longer be Balkanized by the application of varying geographic standards in malpractice cases." Bruce v. Belinkoff, 354 Mass. 102, 235 N.E.2d 793 (1968).

CONCLUSION

The trial court erred in excluding testimony from Dr. Peter Rocovich on the medical standard of care for defendants' performance of a myelogram and a lumbar decompression laminectomy upon Mrs. Jeannette Swan. In excluding said testimony the court applied a version of the anachronistic strict locality rule which is not and should not be the law in Utah.

The non-geographically based similar locality rule and the national standard of the profession rule are those

which most accurately reflect conditions in contemporary medical practice. The latter rule is especially appropriate in this case because both defendants held themselves out as specialists in their profession.

Plaintiff's expert was properly qualified to testify on the applicable standards of medical care under either the similar locality or national standard rules. For this reason plaintiff should have been permitted to reach the jury with her claims of defendants' negligence. The judgment of the lower court must be reversed and a new trial ordered.

RESPECTFULLY submitted this 12 day of May, 1977.

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